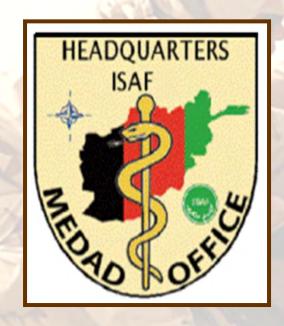


## ISAF HEADQUARTERS

ISAF

Kabul, Afghanistan



## ISAF OVERVIEW BRIEF

MHS Conference
January 2011

**NATO / ISAF UNCLASSIFIED** 

including suggestions for reducing	ompleting and reviewing the collect this burden, to Washington Headqu uld be aware that notwithstanding ar DMB control number.	arters Services, Directorate for Infor	mation Operations and Reports	, 1215 Jefferson Davis	Highway, Suite 1204, Arlington	
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ISAF Overview Brief				5b. GRANT NUMBER		
				5c. PROGRAM E	ELEMENT NUMBER	
6. AUTHOR(S)				5d. PROJECT NUMBER		
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**Report Documentation Page** 

Form Approved OMB No. 0704-0188



### **OUTLINE**



- I. Theater and Organizational Constructs
- II. ISAF Campaign Plan and Theater Health Strategy
- **III.CJMED Lines of Operation** 
  - A. Care for the Coalition
  - B. Enable ANSF Health System Development
  - C. Support Health Sector Development
- IV. ISAF Health Sector Engagement Focus, 2011
- V. Questions / Discussion





### ISAF CAMPAIGN DESIGN



**Protect the Population Jnderstand the Operational Environment** Support Development of ANSF Strategic Communications **Neutralize Insurgent Networks Neutralize Criminal Patronage Networks** Support Development of Legitimate Governance Support Sustainable Socio-Economic Development

Population safeguarded from violence, coercion, intimidation, and predatory groups

ANSF leading in population security, and law enforcement serving the Afghan people

Insurgents neutralized to a level with which ANSF can deal; insurgent ranks substantially reduced by reintegration and reconciliation; cross-border movement of insurgents / explosives reduced significantly; extremist safe havens in Afghanistan denied

CPN threats to GIRoA capacity, Afghan rule of law, and the ISAF/IC mission reduced to a manageable level

Governance sufficiently inclusive, accountable, and acceptable to the people

Licit economy expanding; IC economic support channeled through GIRoA ministries



## JOINT CAMPAIGN PLAN DESIGN







### Support





Conditions Based Transitions



Conditions
Based
Transitions



**NEAR TERM** 

#### **INTERMEDIATE TERM**













#### Supporting Activities

Reintegration/Reconciliation
Transition
Rule of Law
Borders & Customs

Strategic Communications

Reduction of corruption that undermines security and governance





## BUILDING TO MEDICAL TRANSISTION (ISAF MEDICAL LINES OF OPERATION)



### **TRANSITION**

GIRoA Capable of Assuming and Sustaining Execution of Medical Operations

#### <u>CARE</u> FOR THE COALITION

- Sustain Theater Public Health Services
- Provide Medical Care (Including Evacuation)

#### **ASSESSMENT:**

Force Health Protection

#### ENABLE ANSF HEALTH SYSTEM DEVELOPMENT

- Develop Afghan Vision for ANSF
- Provide Effective Advisors and Partners Across ANP / ANA

#### **ASSESSMENT:**

An Effective and Sustainable ANSF

#### <u>SUPPORT</u> CIVIL HEALTH SECTOR DEVELOPMENT

- Improve Coalition Effectiveness and Coordination of Resources
- Provide Clear Guidance to Coalition
- Increase Overall Resources Applied to Determinants of Health (CERP,Donors)

#### **ASSESSMENT:**

Improved Public Health

BUILDING THE MEDICAL "HOUSE" OVERALL ASSESSMENT:

> Theater Medical Campaign

Governance

#### FOUNDATIONAL PRINCIPLES

(Success depends on a solid foundational "Mix")

"Mix") Development

Nutrition

Clean Water

Security

Education / Literacy

Sanitation

OPERATIONAL BATTLE SPACE



ISAF Overview Brief, MHS Co.



## **LINE OF OPERATION #1**

Care for the Coalition



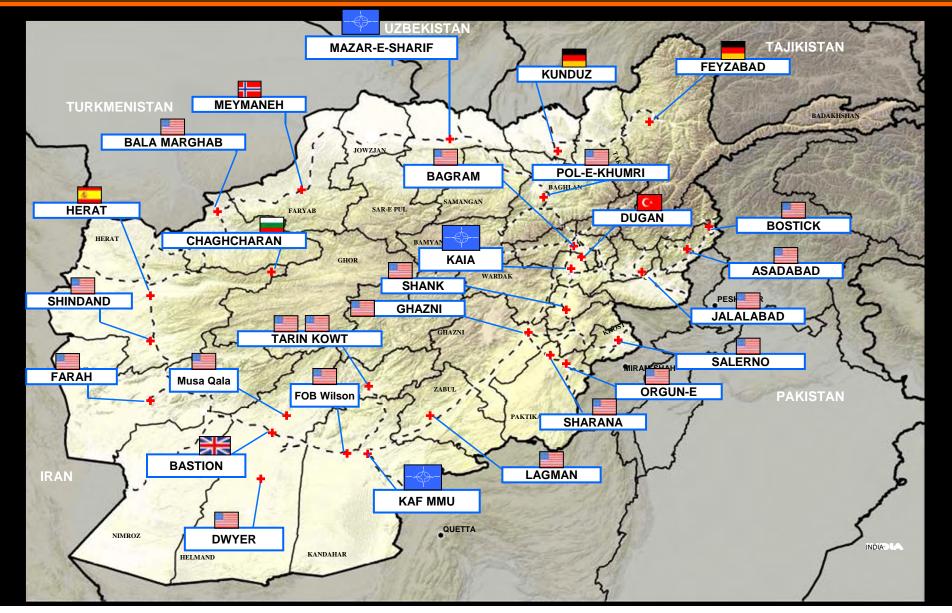
- Capability
- Advances in Care
  - JTTR Data
  - TCCC
  - JTTS 32 CPGs
  - Worldwide Grand Rounds
- MEDEVAC
- STRATEVAC
- mTBI: Concussion protocol and recovery centers





# COALITION HEALTHCARE FACILITIES

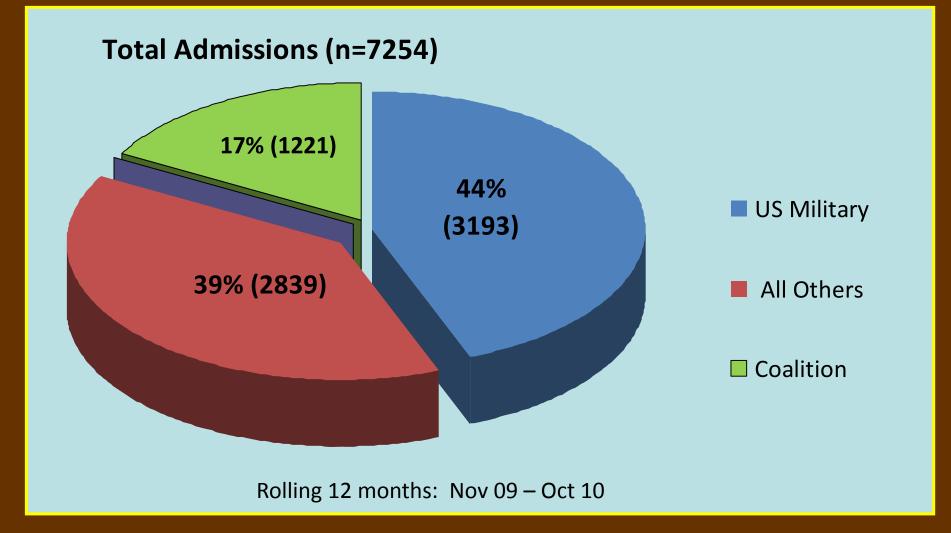






### **OEF ADMISSIONS**



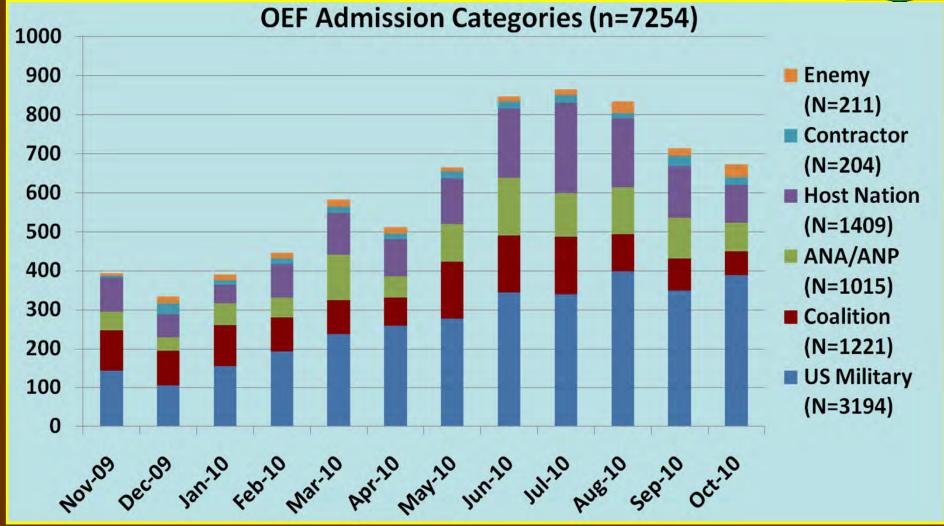






# OEF ADMISSIONS (By Category)



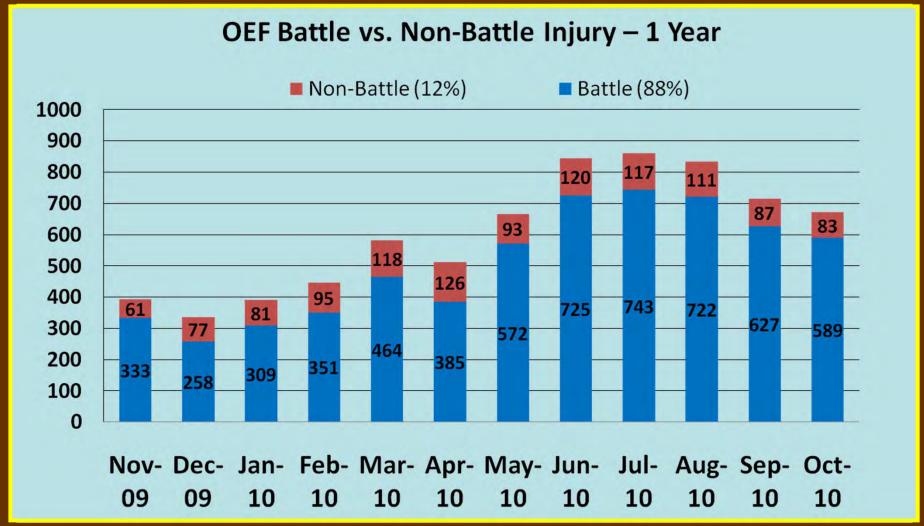






## OEF BATTLE V. NON-BATTLE INJURY (1-Year)



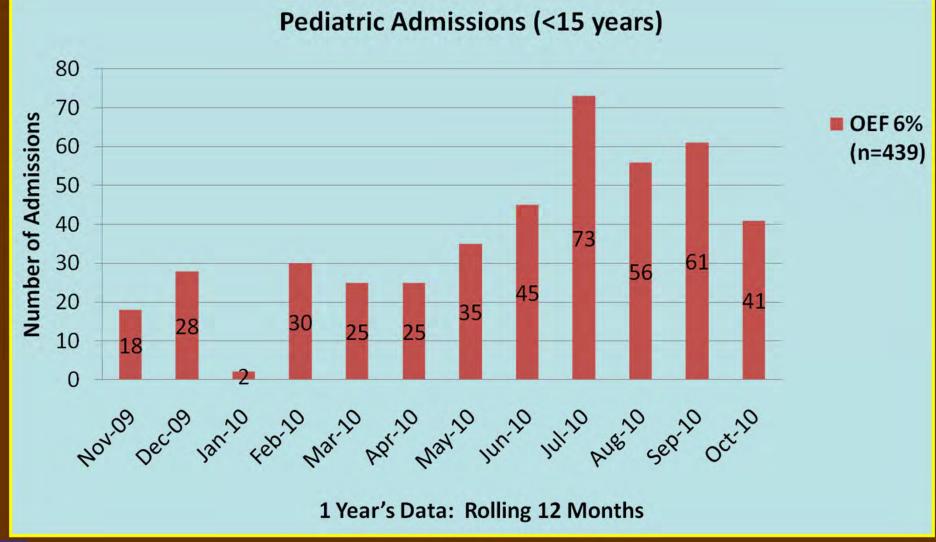






## PEDIATRIC ADMISSIONS (<15 Years)



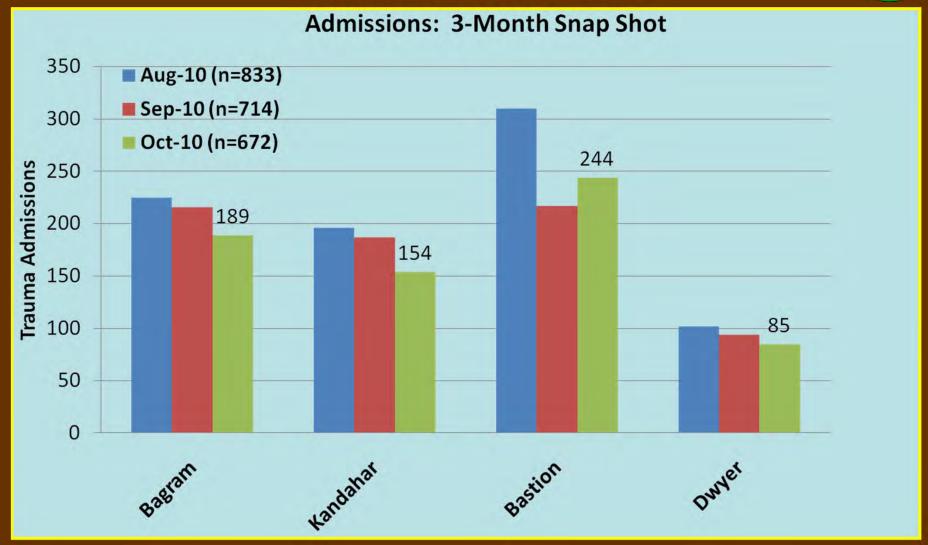






# MONTHLY TRAUMA ADMISSIONS (By Facility)



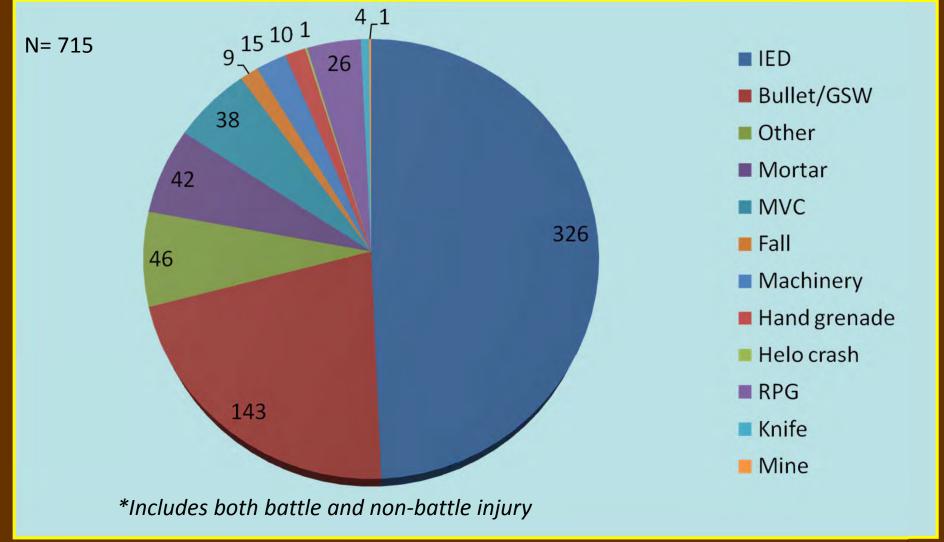






# CAUSE OF INJURY (October 2010)









### **TACTICAL COMBAT CASUALTY CARE (TC3)**



- Battlefied trauma care is different than civilian trauma care
- TC3 focuses on preventable causes of death
  - \*\*Bleeding\*\*
- \*\*Pneumothorax\*\*
- \*\*Airway Obstruction\*\*
- CLS Training is being incorporated into all initial entry training

Care under fire: Combat Lifesaver. Corpsmen or Medic



**Combat Casualty Evacuation Care** 





Protect self & casualty Stop major bleeding Move casualty to cover



Rapid trauma assessment

Treat preventable causes of death

Stabilize and prepare for evacuation



Stabilization and treatment (dependant on evacuation mode)



**Goals of TC3:** 

Treat the casualty. Prevent additional casualties. Complete the mission.





### JOINT THEATER TRAUMA SYSTEM



Institute of Surgical Research
 Clinical Practice Guidelines

 Weekly World-Wide Grand Rounds Joint Theater Trauma System Clinical Practice Guideline

Original Rele	ease/Approval	23 Nov 2010	Note: This CPG requires an annual review.		
Reviewed:	Oct 2010	Approved:	22 Nov 2010		
Supersedes:	This is a new	CPG and must be reviewed in its entirety.			
Minor C	hanges (or)	Changes are	substantial and require a thorough reading of this CPG (or)		

- Goal. To provide an evidenced based framework for the management of pain, anxiety and delirium in injured combot casualties. To provide state of the art pain services to combot casualties and to reduce the incidence of chronic pain syndromes, PTSD and chronic narcotic dependency.
- 2. Background.
  - a. Pain is universally present in combat casualties. Adequate early pain control has been

Joint Theater Trauma System Clinical Practice Guideline

		AMI	PUTATION	
Original Release Approval:		1 Mar 2010	Note: This CPG requires an annual review	
Reviewed:	Feb 2010	Approved:	1 Mar 2010	
Supersedes:	This is a new	CPG and must be reviewed in its entirety		
☐ Minor Changes (or)		Changes are substantial and require a thorough reading of this CPG (or)		
☐ Significan	Changes			

- Goal. To provide standardization of care for the performance of wound management and life saving amputations that will provide maximum limb length preservation, promote healing of viable issues, and facilitate optimal rehabilitative function.
- Background. The notion of the "zone of injury" is dependent upon the mechanism of injury i.e. blast, gunshot and crush injuries, as well as co-morbidities and physiologic status of the

Joint Theater Trauma System Clinical Practice Guideline

#### MANAGEMENT OF PATIENTS WITH CATASTROPHIC, NON-SURVIVABLE HEAD INJURY

Original Release/Approval:		1 Mar 2010	Note: This CPG requires an annual review		
Reviewed:	Feb 10	Approved:	1 Mar 2010		
Supersedes:	This is a new	This is a new CPG and must be reviewed in its entirety			
☐ Minor Changes (ør)		Changes are substantial and require a thorough reading of this CPG (or)			
Significant	Changes				

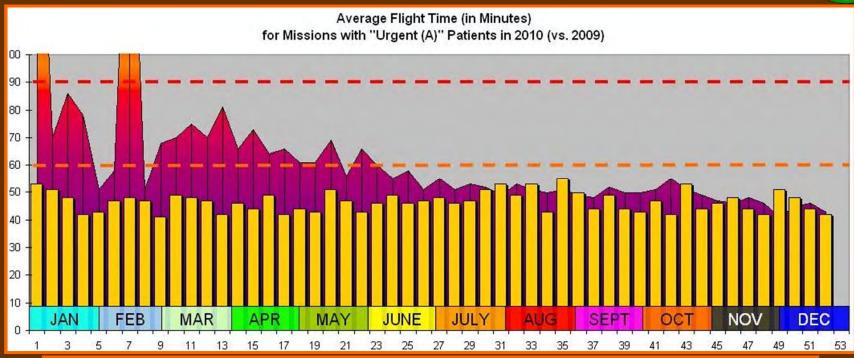
- Goal. Provide useful guidelines for the management of casualties with catastrophic, nonsurvivable head injury at Level II and Level III facilities.
- 2. Background
  - a. Catastrophic head injury, for the purpose of this guideline, is defined as any head injury that is expected after imaging evaluation and/or clinical exam result in the permanent loss of all brain function above the brain stem level. NOTE: For patients with potentially survivable but severe Traumatic Brain Injury, refer to CENTCOM JITS CPG, Management of Patients with Severe Head Trauma).
    - The intent of this guideline is to provide clinically useful recommendations that will allow providers at all echelons who encounter these injuries to optimize the opportunity for these patients to be transported safely and appropriately to the next echelon of care.
    - ii. It is not the purpose of this guideline to address the complexities of brain death

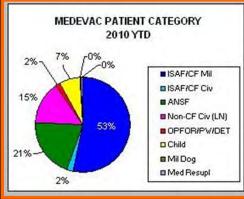


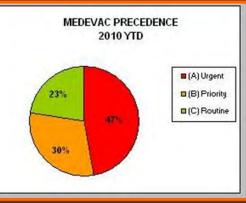


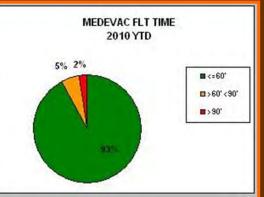
## **MEDEVAC PERFORMANCE**

















### Trauma Bay

2010

US Mil 857

Coalition 209

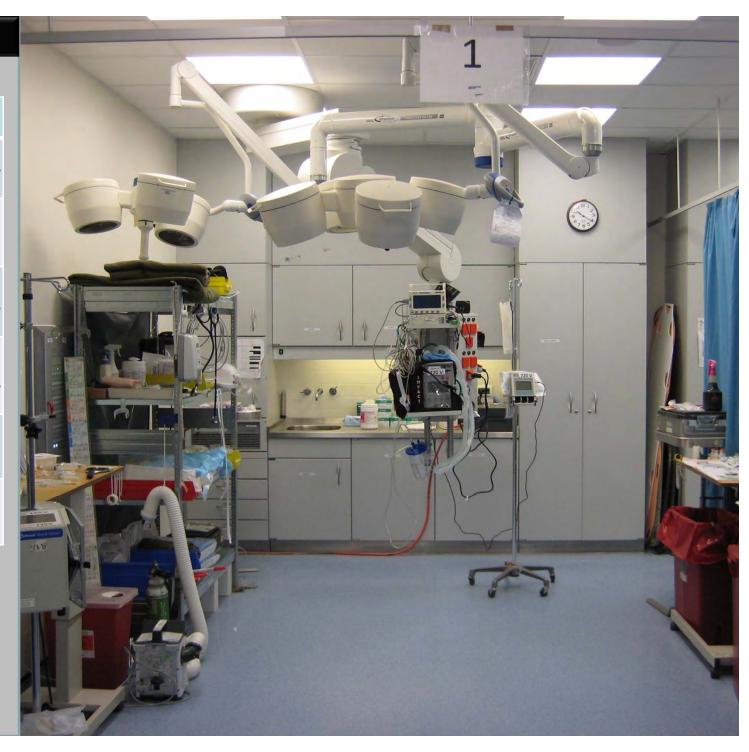
ANA/ANP 257

Afghan

LN 497

Detainee 72

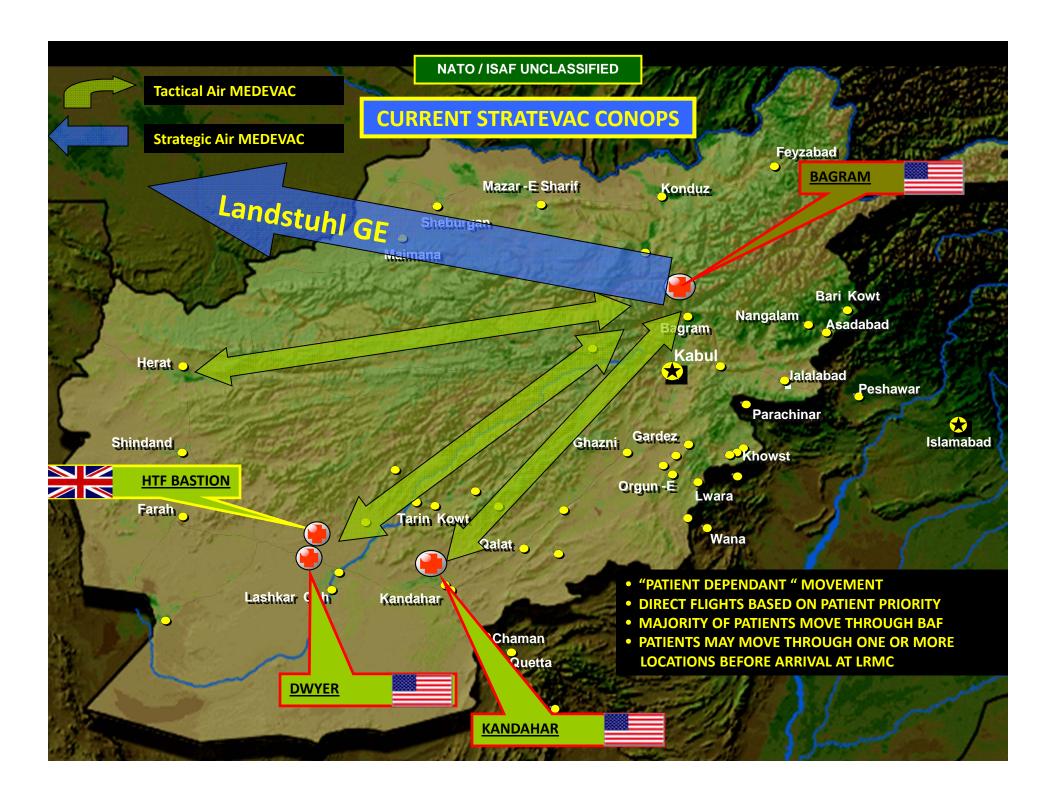
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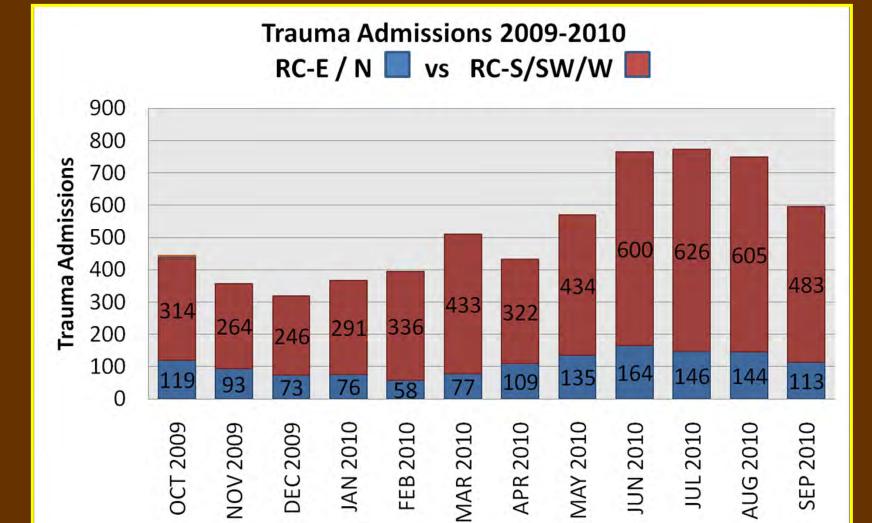


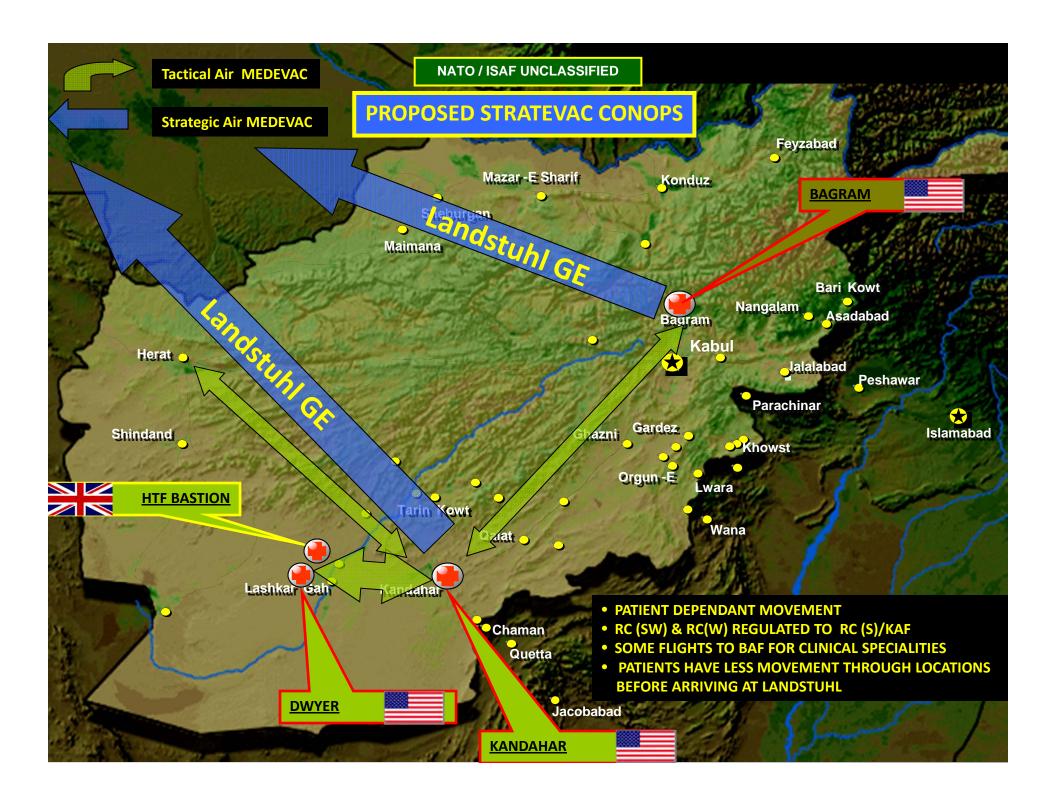




# TRAUMA ADMISSIONS (2009-2010)



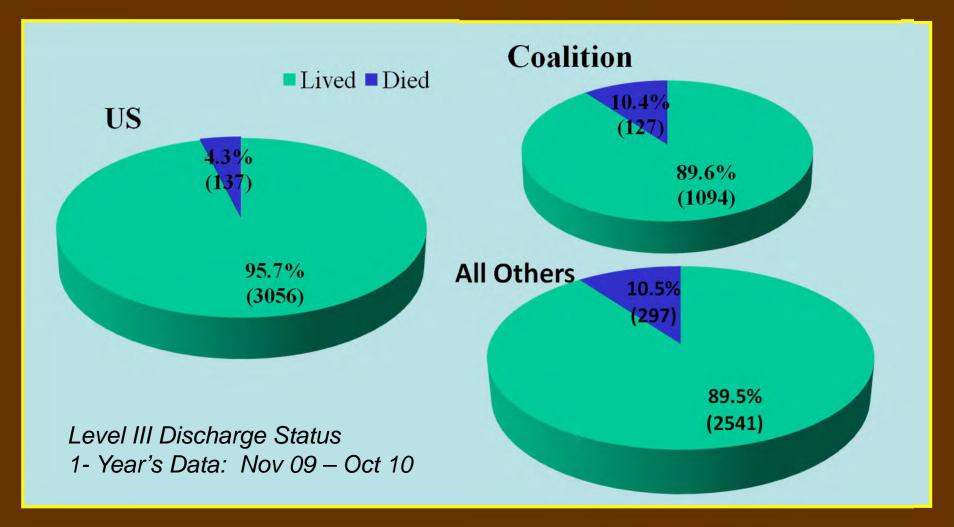






### **OEF IN-THEATER SURVIVAL**









# CONCUSSION CARE (mTBI Initiative)



### Pre-Role I / Role I

FACILITIES	<ul> <li>5 increasing to 8 rest centers (RC-E, RC-S, RC-SW)</li> <li>Core staffing: OT, OT Tech</li> <li>Supported by unit PA / provider</li> </ul>
MISSION	<ul> <li>Facilitate rest in a controlled environment</li> <li>Early ID of Red Flags</li> <li>Appropriate symptomatic management</li> <li>Appropriate referrals to higher level care</li> </ul>
CHALLENGES	<ul> <li>Ensure appropriate medical oversight of soldiers/sailors at rest centers</li> <li>Continuity of medical care</li> <li>Timely assessment / feedback regarding care</li> </ul>
BEST PRACTICES	<ul> <li>Active Surgeon involvement</li> <li>ADOBE Connect sessions between Role I and Role II providers</li> <li>Open lines of communication with neurologist</li> </ul>





# CONCUSSION CARE (mTBI Initiative)



Role III

BAF (RC-E)

KAF (RC-S)

LNK / Bastion (RC-SW)

	, ,	, ,	· · · · · · · · · · · · · · · · · · ·
FACILITIES (RC-E)	<ul> <li>Recurrent concurand managemen</li> <li>Tertiary neurolog</li> </ul>	<ul> <li>Concussion         Restoration Care         Center (CRCC)     </li> </ul>	
MISSION	<ul><li>Neuropsychologist</li><li>PT</li><li>NCO</li><li>Post concussion quarters</li></ul>	<ul> <li>Neurologist</li> <li>Neuropsychologist</li> <li>OT / OT tech</li> <li>PT / PT tech</li> <li>Family medicine</li> <li>LNO for quarters</li> </ul>	<ul> <li>Sports medicine</li> <li>Psychiatrist (inpatient LNO)</li> <li>Family medicine</li> <li>Psychologist</li> <li>Nurse</li> <li>OT / PT</li> <li>0.5 FTE FM (data entry)</li> <li>5 x corpsmen</li> <li>Rely on CASF / step-down unit</li> </ul>
BEST PRACTICES	<ul><li>Near daily multi- disciplinary rounds</li><li>SNCO involvement</li></ul>	<ul> <li>OT military specific functional assessment (warrior tasks)</li> </ul>	<ul><li>Inpatient liaison</li><li>Data capture</li><li>Corpsmen on team</li></ul>



# LINE OF OPERATION #2 Enable ANSF Health System Development



- Afghanistan National Army (ANA)
- Afghanistan National Police (ANP)



## MTAG FUNCTIONS AND KEY INITIATIVES



- <u>Leader Development</u> Advise the ANSF Surgeons General on matters of leadership and policy development.
- <u>Clinical Advising</u> Develop Critical Warfighter Medical Capabilities: Preventive Medicine, Trauma Surgery, Emergency Medicine, Intensive Care, Physical Therapy/Rehabilitation.
- <u>Standard of Care Development</u> Elevate Standards of Care through daily advising to healthcare workers and the healthcare leadership.
  - Formalize Standard of Care policies and procedures.
- Military Medical Training:
  - Combat Medics/Trauma Assistance Personnel
  - Nurses
  - Doctors
  - Allied Health and Technicians (Lab, Radiology, BioMed)
- Key Initiatives:
  - -- Preventive Medicine Tech
  - -- Physician Assistants (PA)







### MTAG SUPPORTED KEY INSTITUTIONS



10

#### Regional ANA Hospitals

Hospital ETTs: 53
DynCorp: 4
Regional combat medics: 24

ANP Medical Facilities

MTAG Medical Advisors:

Regional ANP Advisors:

MPRI:



201st Corps

)

203rd Corps

215<sup>th</sup> Corps 205<sup>th</sup> Corps

Kabul

National Military Hospital: 25 AHPI: 4 MTAG Staff & Advisors: 22

MEDCOM Warehouse: DynCorp: CJSOR (French)

**MTAG Training Courses** 



2 week courses

Combat Medic instructor \*

Med Logistics \*

8 week courses

**Basic Officer Course \*** 

**Combat Medic** 

NCO course \*

52 week courses

**Preventive Medicine** 

**Biomedical Repair** 

Laboratory

Nursing

X-ray

PA start: 1 OCT

\*Afghan Led As of 1 OCT

179 Advisors (68% fill) Throughout Afghanistan



17

A Herat

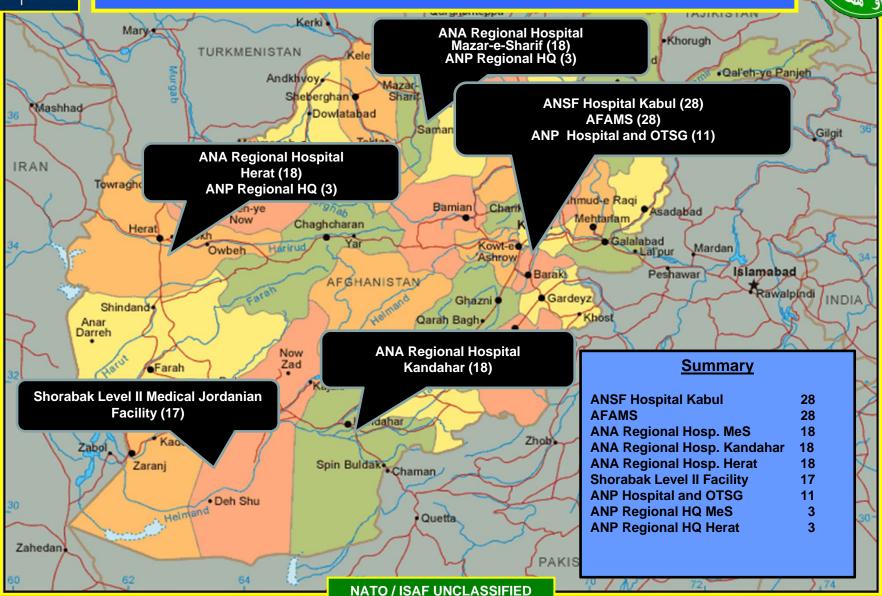
207th Corps

6



### **CJSOR: MTAG**

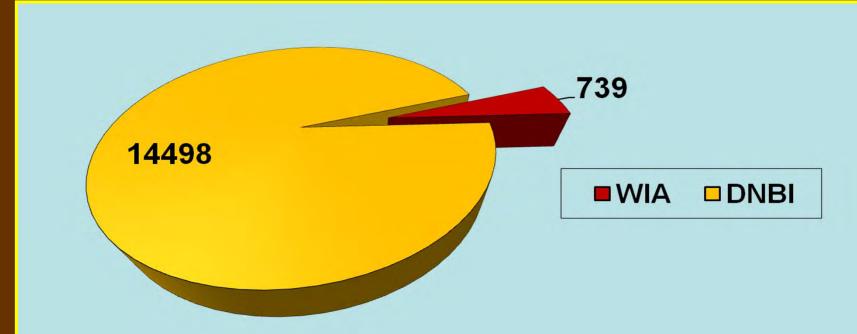
ISAF





### **ANA CASUALTIES**





~20 Disease, Non-Battle Injury (DNBI) casualties for every 1 combat casualty

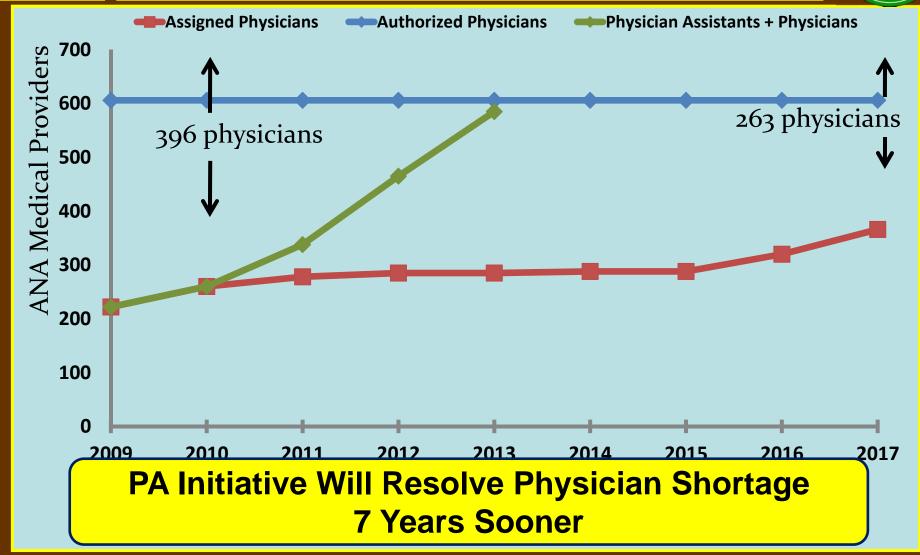
Preventive Medicine = Force Protection Conserve the Fighting Force





### **BRIDGING THE PROVIDER GAP**









### **NEW PA STUDENTS**



## Mentoring Eager Afghans







## **ANSF MEDICAL DEVELOPMENT**



## Challenges for Transition

- Attrition, Leader deficit, Literacy
- Shortage and distribution of physicians (56%)
   and nurses (25%) enterprise-wide
- Delegation of authority / accountability
- Medical logistics
- Need to define clear end-state
- Unfilled mentor requirements and problematic fit to fill process
- MoPH, MoHE, MOD, MOI coordination and sharing





## LINE OF OPERATION #3 Support Civil Health Sector Development



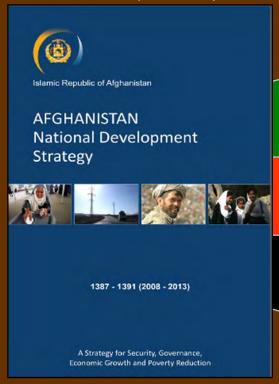
- Afghan Development Strategy
- ISAF Guidance
- Focus for 2011 Engagement



## AFGHAN NATIONAL HEALTH POLICY



#### **ANDS (MDGS)**





### **Implementing SOPs**



BPHS and EPHS Comprise Afghanistan's Entire Referral System



## AFGHAN HEALTH AND NUTRITION STRATEGY





#### Health & Nutrition Sector Strategy Vol. 2

- Desired results (Health Indicators)
- Vision
- Goals
- Objectives
- Programs



#### Essential Package for Hospital Services in AFG

- Capabilities
- Equipment
- Staffing
- Drugs



### Basic Package for Health Services in AFG

- Capabilities
- Equipment
- Staffing
- Drugs

Regional Provincial

30

**67** 

District Hospital (DH)

100k-300k

**XRAY**, surgery, OB, physiotherapy, pediatrician, pharmacist, dentist.

Comprehensive Health Ctr (CHC) 30k-60k

Limited inpatient care, lab, pharmacy. Severe childhood illness, malaria. Complex mental health. 2 doctors (male/fem), 2 nurses, 2 midwives.

### Basic Health Center (BHC) 15k-30k

Complex outpatient care, mental health. Full OB care, newborn care, immunizations, childhood diseases. Treatment of malaria, TB.

1 doctor, 1 nurse, 1 midwife, 2 vaccinators. Supervise CHW.

#### Mobile Health Team 10k-15k

An extension of the BHC. Visits remote villages every 2 months or as directed by PHCC. 1 male doctor or nurse, 1 female midwife or nurse, 1 vaccinator, and 1 driver.

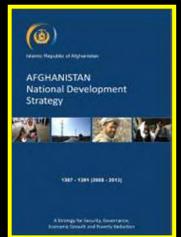
#### Health Sub-Center

3k-7k
Created to increase access within 2 hours walk. Routine immunizations, prenatal care, TB detection, 1 male nurse & 1 community midwife. Supervises HP.

#### **Health Post**

#### **Covers 1,000-1,500 Afghans**

**Limited care**: treatment of malaria, diarrhea, acute respiratory infections. **Education** on nutrition, birth control, STDs, prenatal warning signs. **Identification** of persons with disabilities and mental health illness. **2 CHWs** from their home.



**Number of Facilities** 

(HMIS, Sep 2010)

813

378

117

Data Unavailable

Man



### **MoPH STRATEGY**



- Focused on reducing maternal and child mortality as the key element
- Delivers a basic, not comprehensive, health package (BPHS)
- Secondary care, but minimal tertiary care (EPHS),
   e.g., no publicly funded ICU capability
- NGOs contracted to provide BPHS throughout the country
- MoPH's role is steward of the health system (far from perfect, but it works)



## **ISAF DIRECTION AND GUIDANCE**









#### **ISAF Standing Operating Procedures 01154:**

ISAF Guidance on Military Medical Engagement in Health Sector Reconstruction and Development



#### **COMISAF DIRECTIVE, 09 NOV 10:**

ISAF Medical Involvement in Civilian Health Care



COMISAF/CDR USFOR-A

10 NATORSAF and US Forces-Alghamstan Commanders

Fig. the surgoses of this latter, any activity that involves establishing Coalition princip, usually temporary, to provide direct medical care to Afghans will be referred to as Mocical Civil Action Programs (MEDCAPs).

2. Dus to this resist consistence of the in Algametan, it is not surprising that access in relation can a one of the most herpointry insectic concess by village and tools in relation can be one of the most herpointry insectic concess by village and tools the control of the

1. More importantly. MEIGCAPP, in no comet to CDN afforts to create inspects of the common of the

d. When considered objectively, the negative aspects of MEDCAPs can ourweight in limited or short-term observe effects may produce. Therefore, pre-channel internal of outside hardwards should be ferred to those that assert Official in developing a suitainable health care system that controlles to our sinfeet OON strategy subject in Cales where the urgency of the medical need outside sin as potential.

5. Alternatively, there are many types of medical engagements that can productions and sating health benefits while minimizing the potential for respectives and sating health benefits while minimizing the potential formation consistences. For example, the development of the Medical Seminar (MEDSEN stone) by CLSOTE-A has the potential to deliver a positive CON effect. The

program jams to connect isolated zommunities to GIROA Hrough sustainable in-medically sound interventions by Aphains that Asives awariness and improves public health officer installings to raise public health awareness improve sanitation provide agreement among water facilities for a sepublic health awareness improve sanitation provides agreement among water facilities the application of MoPH-approved training programs, complete selected unlessfulcture projects, and provides mentioning incommunities of Aphain health care providers can provide provide COIM effects.

d Tres guidance does not change (SA) is established Medical Rules of Eiglibrity or the Just governing out intervention of Junia price numberodes or analysis disasters. If sites codes not alter SHAPP Guidance that siys out appropriate instancy modical engagements focused on building OfRoA's capacity. Not does it contradict the process for doming with investable VPP recognists for several consisteration.

Vinins commanders are conducing CORN in areas where there is no head-those provision the conduct of a MEDCAR will not only the two dis medical services or as commander of the MEDCAR will not only the two medical services. MCDCAR MCMHROD are considered from the commander of the medical services MCMHROD are considered provisions services. Where there is no medical provisions are presented in significant or medical services. Where there is no medical consideration considered area outlined by the potential name of effects.

It is come commanders may leed this is an unvestigant lead to their freedom of action. To alloy those concerns recognise that force protection considerations may acknowly the natural effects outlined above. Moreover, I know commanders need MEDICAR's when the commander determines that they are warrander. In these cases, notewer we will lay to employ Alghan divitan health professionals to deliver parent; care. I also wwint to be very clear that these MEDICAR's chical and to parent; care. I also when to be very clear that these MEDICAR's chical and to the control of the control of

I I expect commanders at all fevels to comply with ISAF SOP 0.1194\* when planning and executing Modical Engagements, and to ensure that their Modical Advisors record on these activities through the standard weekly Medical Assessment Report process.

Thank, fram!

David H Petraeus General United States Army Commander International Security Assistance

Soft SOF 2:147 Mencial Support to Lossy VIPs.

Not Describe 6.2 Foundation on Mindre Valuetal services memberged and to standards

sometime and plagned to Control and Soft Medical services and on and Control present

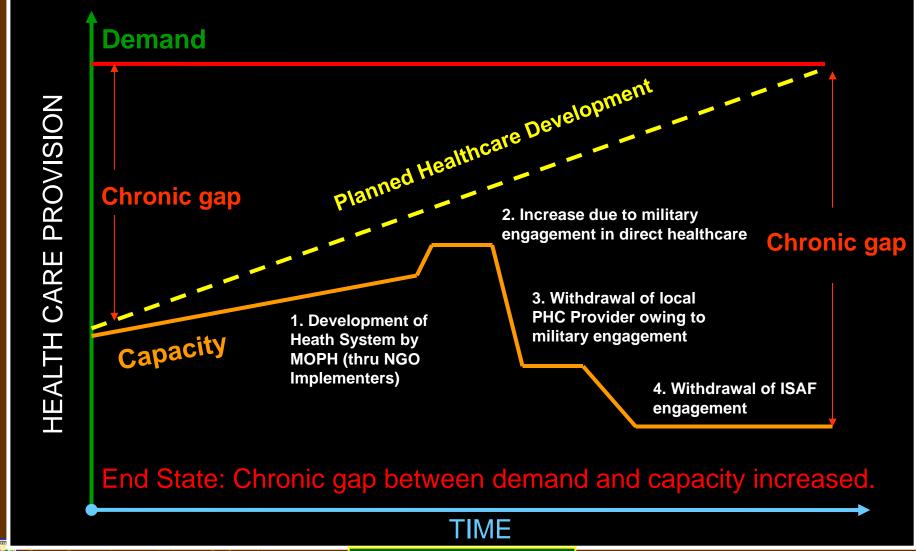
for Control and Control on VIV List Medical Engagement of teach Electric Medical Engagement of the Control and Co





## UNINTENDED CONSEQUENCES THE PERFECT STORM SCENARIO







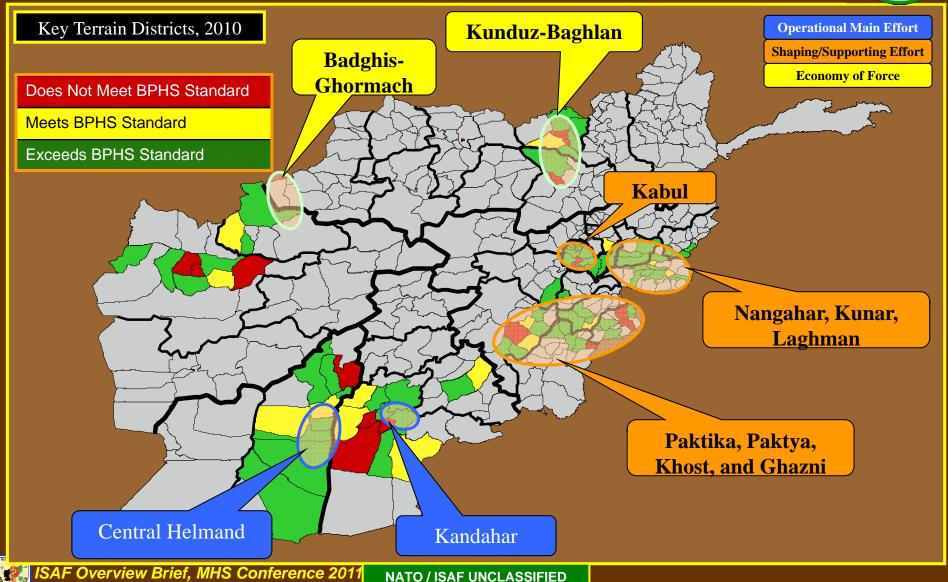


# Focus for ISAF Engagement 2011



## EXISTING HEALTH FACILITIES COMPARED TO BPHS BENCHMARKS







## **HUMAN CAPACITY BUILDING**





### **Civil Sector Mentoring/Training**

- Agreed with MOPH and BPHS/EPHS implementer
- Do not conduct if civilians able to provide training
- Use only MOPH approved standards and curricula
- Focus on training the Afghan trainer

### **ANSF Mentoring/Training**

- Main effort for spare capacity
- Pivotal to security sector reform
- Competent and self-sustained medical service capable of supporting independent ANSF operations
- Significant challenges: shortage of mentors, weak leadership





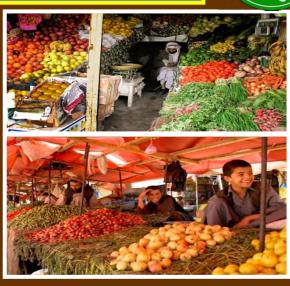


## WIDER DETERMINANTS OF HEALTH









- Average life expectancy is 42 ((regional average (RA) is 64))
- 1 in 5 children will die before the age of 5 (RA is 1/11)
- Improving the wider determinants of health (clean water, sanitation, nutrition, and vector control) will enhance public health
- Access to safe drinking water is assessed at 27% (low: 5%; high: 56%)
- Access to adequate sanitation facilities (urban: 21%; rural: 1%)

Source: National Risk and Vulnerability Report 2007/08





## PASSIVE SUPPORT TO POLIO ERADICATION CAMPAIGN



- Promulgate the national and subnational immunization days to all regional commands
- Further FRAGO issued prior to each NID and SNID in order to 'deconflict' where possible
- Joint USAID / WHO Brief to COMISAF 11 January 11 (tentative)





#### **Guidance Provided**

- Do not offer direct support
- Do not intervene
- Do not prevent or direct vaccination
- Distance themselves from the program
- Appreciate importance of the program





## **FINAL THOUGHTS**



"It is better to let them do it themselves imperfectly than to do it yourself perfectly. It is their country, their way, and our time is short."

- T E Lawrence

"When confronted with heartbreaking situations, we must choose the hard right rather than the easy wrong"

LTCs Rice and Jones, US Army







## THEATER MEDICAL C2 OVERVIEW



